

## Patient Forms

Seeing Doctor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us? \_\_\_\_\_  Male  Female

Who is your Primary Care Dr? \_\_\_\_\_

### Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Nickname \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Social Security # \_\_\_\_\_

(Primary) Phone: \_\_\_\_\_  Home  Work  Other

(Secondary) Phone: \_\_\_\_\_  Home  Work  Other

May we leave a voicemail with medical information?  Yes  No

**Patient under 18?**  Yes  No

(If yes, please fill out all that is below)

Guarantor's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Policy Holder Information**  Same as Patient

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

SS/ID # \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Address (if Different from Patient) \_\_\_\_\_

**Primary Insurance** (who is the policy holder?)

Patient  Guarantor  Other

Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_

Group # \_\_\_\_\_

**Email Address**

\_\_\_\_\_

Employer \_\_\_\_\_

Employer Phone # \_\_\_\_\_

Is this work related?  Yes  No

Policy Id# \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Adjuster's Phone \_\_\_\_\_

**Secondary Insurance** (who is the policy holder?)

Patient  Guarantor  Other

Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_

Group # \_\_\_\_\_

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay what I owe to this office upon request. If my account is referred to a collection agency, I agree to pay collection expenses including attorney's fees. My health insurance or other benefits relating to my medical condition are available to cover the cost for treatment provided by this office. I hereby assign those benefits to this office to be applied to my bill. A copy of this authorization shall be valid until rescinded in writing or replaced by one at later date.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient/Guarantor's Signature: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Medications: <input type="radio"/> YES (List Medications & over the counter supplements below) OR <input type="radio"/> NO (I do not take medications)		
Name Of Medicine	Dosage & How often taken	Reason for taking medication.

Allergies : <input type="radio"/> YES (List Below) <input type="radio"/> NO Allergies	Reaction

Surgical History: (Please list surgeries, hospitalizations) <input type="radio"/> None	Dates

Doctors: Please list all doctors currently involved in your care.		
Name	Phone #	Reason

<b>Family Medical History</b>	<b>Mother</b>	<b>Father</b>	<b>Siblings</b>	<b>Paternal Grandmother</b>	<b>Paternal Grandfather</b>	<b>Maternal Grandmother</b>	<b>Maternal Grandfather</b>
<input checked="" type="checkbox"/> High Blood Pressure							
Lung Disease							
Bleeding Problems							
Diabetes							
Stroke							
Heart Disease							
Cancer (Specify what type)							
Other Family Members:							

### Personal Social History

Tobacco Use	<input type="radio"/> Never <input type="radio"/> Quit/When _____ <input type="radio"/> Current Smoker/Packs Per Day: _____
Alcohol Use	Yes / No in the past year?   How many per day _____ ?
	How often: Monthly or less, 2-4 times per month, 2-3 times per week, 4+ a week?
	How many drinks per day?   1-2   3-4   5-6   7-9   10+
	How often did you have 6+ drinks on one occasion?   Never   Monthly   Weekly   Daily
Drug Use	<input type="radio"/> Never   Type/Frequency _____
Occupation	

### Past Medical History

<b>Anemia?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Depression?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Kidney Stones?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Anxiety?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Gout?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Pancreatitis?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Arthritis?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Heart Disease?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Panic Attacks?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Asthma?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Heart Mummur?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Rashes?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Bladder Infection?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>High Blood Pressure?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Rheumatic Fever?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Bleeding Problems?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Hepatitis?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Seizures?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Blood Transfusion?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>High Cholesterol?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Stroke?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Cancer?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Infections?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>TB?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>COPD?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Inflammatory Bowel Disease?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Thyroid Disease?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Diabetes?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Obesity?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Ulcer?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Other?</b> <input type="radio"/> No <input type="radio"/> Yes (if yes explain)					
<b>If Yes to cancer, What type?</b>					

Review of Symptoms					
General		Endocrine		Gastrointestinal	
Weight Gain	O Yes O No	Excessive thirst	O Yes O No	Nausea	O Yes O No
Weight Loss	O Yes O No	Thyroid disease	O Yes O No	Vomiting	O Yes O No
Fever	O Yes O No	Hormone problem	O Yes O No	Abdominal pain	O Yes O No
Fatigue	O Yes O No	Musculoskeletal		Rectal bleeding	O Yes O No
Change in appetite	O Yes O No	Leg Cramps	O Yes O No	Bowel problems	O Yes O No
Night Sweats	O Yes O No	Muscle Aches	O Yes O No	Allergy/Immunology	
Ophthalmologic		Joint Stiffness	O Yes O No	Food allergy	O Yes O No
Blurred Double Vision	O Yes O No	Swollen Joints	O Yes O No	Other	O Yes O No
Glasses/Contacts	O Yes O No	Joint Pain	O Yes O No	Psychiatric	
Glaucoma	O Yes O No	Genitourinary		Insomnia	O Yes O No
Eye Disease/Injury	O Yes O No	Kidney Stones	O Yes O No	Confusion/Memory loss	O Yes O No
ENT		Blood in urine	O Yes O No	Depression	O Yes O No
Ringing in the ears	O Yes O No	Testicle pain	O Yes O No	Breast (Including Men)	
Sore Throat	O Yes O No	Menstrual Problems	O Yes O No	Nipple Discharge	O Yes O No
Sinus Problems	O Yes O No	Neurologic		Breast Pain	O Yes O No
Decreased Hearing	O Yes O No	Tingling/Numbness	O Yes O No	Breast Lump	O Yes O No
Nose bleed	O Yes O No	Convulsions/Seizures	O Yes O No	Women Only	
Cardiovascular		Frequent headache	O Yes O No	Are you Pregnant	O Yes O No
Chest Pain at rest	O Yes O No	Paralysis/Tremor	O Yes O No	If so, How far along?	
Chest pain with exertion	O Yes O No	Loss of use of extremity	O Yes O No	O 1st Trimester O 2nd Trimester O 3rd Trimester	
Palpitations	O Yes O No	Hematology		Number of pregnancies?	
Heart Trouble	O Yes O No	Bruise Easily	O Yes O No	O 0-2 O 3-5 O More than 5	
Fluid accumulation in legs	O Yes O No	Slow to heal	O Yes O No	Number of Deliveries	
Respiratory		Enlarged glands	O Yes O No	O 0-2 O 3-5 O More than 5	
Shortness Of Breath	O Yes O No	Skin		Did you breast feed?	
Shortness of Breath with exertion	O Yes O No	Rash	O Yes O No	O Yes O No	
Wheezing/Asthma	O Yes O No	Itchy	O Yes O No	If Yes, Are you currently Breast Feeding?	
Coughing up blood	O Yes O No	Change in hair/nails	O Yes O No	O Yes O No	

**Patient Statement:** To the best of my knowledge, the above information is accurate and complete and I acknowledge that I have been presented and read a copy of the Office Policies and The Practice's Notice of Privacy Practices in the new patient paperwork packet.

**Patient/Guarantor Signature** \_\_\_\_\_

**Pharmacy Information**

**Name and Number/Cross Streets:**

\_\_\_\_\_

**Emergency Contact**

**Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

May we speak to your emergency contact if he/she contacts us on your behalf?  Yes  No

**Please list the names and phone numbers of those individuals involved in your care or with whom you will allow us to share your health and treatment information – including family members and friends: (If none put N/A)**

<b>Name:</b>		<b>Phone:</b>	
Relationship:		Alternative Phone:	
<b>Name:</b>		<b>Phone:</b>	
Relationship		Alternative Phone:	
<b>Name:</b>		<b>Phone:</b>	
Relationship:		Alternative Phone:	

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**Patient Request for Email Communications**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Communications over the Internet and/or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email. To request that this provider communicate with you via email you must complete this form and return it to your health care provider's office.

**Please be advised that:**

- (1) This request applies only to the healthcare provider or program that you indicate below. If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.
- (2) Advanced Surgical Associates will not communicate health information that is specially protected under state and federal law (e.g. HIV/AIDS, substance abuse, and mental health information) via email.
- (3) Your request will not be effective until you receive and respond to a test email message.

**Please provide the answer to the question below for your test email:**

The street number of my Residence: \_\_\_\_\_

**I understand and agree to the following:**

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have read and understood the Patient Email Communication and I am able to request a copy of this form.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communication this way.
- I understand that all email communications in which I engage may be forwarded to other provider for purposes of providing treatment to me.
- I agree to hold Advanced Surgical Associates and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

\_\_\_\_\_  
Signature of patient or personal representative\_\_\_\_\_  
Date\_\_\_\_\_  
If personal representative, authority to act on  
Behalf of the patient**Advanced Surgical Associates**\_\_\_\_\_  
Name of Physician or Program